Kansas Health Care Provider Insurance Availability Act

Non-Resident Health Care Provider Certification Form (July 2014)

A CERTIFICATE OF INSURANCE IS REQUIRED

Section 1 – Health Care Provider Identification and Residency

Health care provider's name: _____
Last name, first name, middle initial, and professional acronym

Legal residence (cannot be Kansas): _____
Street address, city, state, zip code, and country

Daytime phone number: _____ Email address: _____

Mailing address (if different from residence): _____
Street address, city, state, zip code, and country

Section 2 – HCSF Coverage and Health Care Provider Credentials

A. Health Care Stabilization Fund coverage:

Year of HCSF compliance (select one) ◯ 1st yr ◯ 2nd yr ◯ 3rd yr ◯ 4th yr ◯ ≥5th yr

HCSF coverage limits (select one) ◯ $100,000/$300,000 ◯ $300,000/$900,000 ◯ $800,000/$2.4M

B. Statutory credentials:

Kansas licensing agency _____ Kansas License number _____

Professional specialty _____ HCSF classification group number _____

Section 3 – Insurance Policy and Information *(certificate of insurance is required for each submission)*

Insurance company name: _____

Insurance company address: _____
Street address, city, state, zip code, and country

Insurance policy number: _____ Type of coverage: ◯ Claims made ◯ Occurrence

Renewal or effective date: _____ Expiration date: _____

Section 4 – HCSF Surcharge Calculation

Annual HCSF surcharge selected from surcharge rate tables $ _____ or annual HCSF surcharge calculated based on commercial insurance premium multiplied by HCSF surcharge percent $ _____ . Percent of professional practice in Kansas ____ % [This ratio may be the result of the number of days for a locum tenens assignment divided by 365 days if the primary policy is short-term (six months or less), or it may be a reasonable estimate comparing the amount of patient care provided in Kansas compared to the health care provider's total professional practice during a twelve month period. The percent should be rounded to the nearest whole number and may not be less than one percent.]

HCSF Premium Surcharge Payable: $ _____ **NOTE:** The minimum surcharge payable per compliance period is $50.

Section 5 – Health Care Provider's Certification

I hereby certify that: (1) I am maintaining a policy of professional liability insurance with limits of not less than $200,000 per claim and $600,000 annual aggregate coverage in accordance with the Kansas Health Care Provider Insurance Availability Act, (2) the above information is true and correct to the best of my knowledge, and (3) I will notify the HCSF Board of Governors in the event of any changes in my professional liability insurance coverage.

Signature: _____ Date signed: _____

HCSF USE ONLY